Whitesburg Baptist Biblical Ministry
Personal Data Inventory

I. Contact Information

Name: ____ Date: ________________________

Email Address: _________________________________ Home: ________________________

Gender: _________ Birth Date/Age: _________________ Work: _________________________

Employer/Occupation: ____________________________ Cell: _________________________

List the people who currently live in your household:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Emergency Phone Number: ______________________________ Only used in case of emergency.

II. Spiritual History:

What church do you currently attend: ____

Pastor's name; ____

Church attendance per month: ____________________________

Do you believe in God? Yes____ No____Uncertain ____

Are you a Christian? Yes ____ No____ Becoming One ____

Have you been baptized? Yes ____ No ____ When? ____

Describe your salvation experience:

Describe your relationship with Jesus Christ now:

How often do you read the Bible? Never ____ Occasionally ____ Regularly ____

Do you have personal devotions? Never ____ Occasionally ____ Regularly ____

Describe your personal devotions:

Do you have family devotions? Never ____ Occasionally ____ Regularly ____

Describe your family devotions:

Explain any recent changes in your spiritual life:

III. Personal History:

Briefly describe your life.

Early Childhood:

Adolescence 10-17:

Marital Status:

Single _____ Dating/Engaged _____ Married _____
Separated _____ Divorced _____ Widowed _____

Complete if dating or engaged:
Date you met: _____ Length of dating: _____
Are you planning to marry? _____ Expected date of wedding? _____

Complete if you are married:
Length of steady dating with spouse: _____________ Date of marriage ________________
Length of engagement: ____________ Ages at time of marriage: Husband _____ Wife _____

Briefly describe your relationship:

Is your spouse willing to come to counseling? Yes _____ No _____

Children's Names	Age	Gender	Living at home	Education (in years)	Marital Status (*PM)

*Check if this child is from previous marriage.

IV. Medical History:

Rate your physical health: Very Good _____ Good _____ Average _____ Declining _____ Other _____

Date of last medical examination: ____________________ Report: _____________________________________

Your physician: __________________________________ Address _______________________________________

Are you taking any medications currently? Yes _____ No _____ If yes, please answer below:

Medication	Dosage	Frequency

Please describe any current medical condition or history pertinent to problem:

Have you received any therapy, psychotherapy, counseling, or treatment in the past year? Yes _____ No _____

If yes, when? ____________________ With whom? ____

How often? ____________________________ Reason(s) ____

V. Current Personal Information:

Do you consume alcohol? _____ How often? ____________________ How much? ________________________

Have you ever used drugs for non-medical purposes? _____

If yes, please explain:

Have you ever been arrested? _____

If yes, please explain:

What is your average daily caffeine consumption? Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks.

Sleep Patterns (Answer YES or NO):

Do you have trouble falling to sleep? _____

Do you awaken frequently in the night? _____

Do you use sleep medications? _____

Do you have sleep apnea? _____

Do you have difficulty staying asleep? _____

Do you generally nap during the day? _____

Do you feel rested when you awaken? _____

On average, what time do you go to bed? _____ Wake up _____

Are your weekend sleep pattern different from weekdays?

Explain: ____

Please note the average number of times per week spent on each of the following activities:

Cleaning _____

Computer _____

Gaming _____

Grooming _____

Hobbies _____

Movies _____

Reading _____

Shopping _____

Sports _____

Work _____

Television _____

Social Networking _____

Texting/Cell Phone _____

Please **mark** any symptoms that you have had in the past **six months**:

- ❑ Change in appetite
- ❑ Low motivation
- ❑ Fatigue/low energy
- ❑ Depressed mood/sadness
- ❑ Anxiety/fear
- ❑ Panic
- ❑ Problems concentrating
- ❑ Isolating from others
- ❑ Frequent anger
- ❑ Tearful/crying spells
- ❑ Hopelessness
- ❑ Other

Please **mark** any of the following that best describe you **now**:

❑ Active	❑ Fearful	❑ Bitter	❑ Good natured	❑ Forgetful	❑ Impatient
❑ Persistent	❑ Ambitious	❑ Self-confident	❑ Shy	❑ Moody	❑ Distracted
❑ Kind	❑ Nervous	❑ Self-conscious	❑ Impulsive	❑ Serious	❑ Suspicious
❑ Introvert	❑ Excitable	❑ Hardworking	❑ Frustrated	❑ Leader	❑ Angry
❑ Extrovert	❑ Likable	❑ Imaginative	❑ Sensitive	❑ Rebellious	❑ Cynical
❑ Quiet	❑ Lonely	❑ Easy-going	❑ Submissive	❑ Calm	❑ Other

Have you ever had a severe emotional upset (YES or NO) ______
If yes, please explain:

Have you attempted suicide? Do you currently struggle with suicidal thoughts? (YES or NO) ______
If yes, please explain:

Have you had or have an eating disorder? (YES or NO) ______
If yes, please describe:

Please mark all issues that apply:

- ❑ Addiction
- ❑ Adultery
- ❑ Anger
- ❑ Anxiety
- ❑ Apathy
- ❑ Appetite
- ❑ Bitterness
- ❑ Children
- ❑ Communication
- ❑ Conflict (fights)
- ❑ Deception
- ❑ Decision Making
- ❑ Depression
- ❑ Drunkenness
- ❑ Envy
- ❑ Fear
- ❑ Finances
- ❑ Fornication
- ❑ Gambling
- ❑ Gluttony
- ❑ Grief
- ❑ Health
- ❑ Homosexuality
- ❑ In-Laws
- ❑ Impotence
- ❑ Lifestyle Change
- ❑ Loneliness
- ❑ Lust
- ❑ Memory
- ❑ Moodiness
- ❑ Perfection
- ❑ Pornography
- ❑ Rebellion
- ❑ Sex
- ❑ Sleep
- ❑ Spouse Abuse
- ❑ Other

1. What circumstances/issues led to your request for Biblical Counseling at this point in time?

When did this begin? Please specify a date if possible.

Please describe any other significant events occurring at that time.

2. How have you tried to resolve these issues?

3. What are your goals for counseling?

4. Is there any other information we should know?